DRAFT
Violence Against Women

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Definition: Violence against women is actual or threatened physical or sexual violence, stalking, and psychological/emotional abuse toward women.

Washington State Goal Statements:

- Develop a foundation for collecting critical data to accurately assess the magnitude of the problem
- Assess the effectiveness of interventions, and promote use of effective strategies.

National Healthy People 2010 Objectives:

1. Reduce the rate of physical assault by current or former **intimate partners from 4.4 (1998) to 3.3 physical assaults per 1,000 persons aged 12 years and older.
2. Reduce the annual rate of rapes or attempted rapes from 0.8 (1998) to 0.7 rapes or attempted rapes per 1,000 persons aged 12 years and older.
3. Reduce sexual assault other than rape from 0.6 (1998) to 0.4 sexual assaults other than rape per 1,000 aged 12 years and older.
4. Reduce physical assaults from 31.1 (1998) to 13.6 physical assaults per 1,000 for persons aged 12 years and older.

** **Intimate partner(s):** Refers to spouses, ex-spouses, boyfriends, girlfriends, and former boyfriends and girlfriends (includes same-sex partners). Intimate partners may or may not be cohabitating and need not be engaging in sexual activities.

Statement of the Problem:

Violence against women (VAW) is a broad term which incorporates intimate partner violence (IPV), sexual violence by any perpetrator, and other forms of violence against women (e.g., physical violence committed by acquaintances or strangers). Violence is divided into four categories:

- Physical violence
- Sexual violence
- Threat of physical or sexual violence

- Psychological/emotional abuse (including coercion tactics) when there has also been prior physical or sexual violence, or prior threat of physical or sexual violence.[i]

A group of international experts convened by the World Health Organization (WHO) in February 1996 agreed that the definition adopted by the United Nations General Assembly provides a useful framework for the Organization's activities. The *Declaration on the Elimination of Violence against Women* (1993) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

Violence against women and girls is a major health concern. Millions of women are victims of sexual assault, dating or domestic violence, or stalking at some point in their lives. Women can experience physical, sexual, or mental abuse throughout their lifecycle; violence can occur in infancy, childhood, adolescence, and/or during adulthood.

The health effects of violence against women are extensive. In addition to possible acute injuries sustained during sexual assault or domestic violence, physical, sexual, and psychological abuse are linked to numerous chronic adverse health and mental health conditions. Violence against women can cause its victims increased susceptibility to many adverse health effects. These can include alcohol and substance abuse, sexually transmitted diseases, depression, and suicidal attempts. Victims of violence are more likely to appear in health care settings for conditions that seem unrelated to their history of abuse: complaints of pain, insomnia, gastrointestinal problems, and irritability.

Social and health systems are not well prepared to address violence against women in a routine manner, therefore, too many victims never discuss incidences of violence with anyone or approach the health, mental health, criminal justice, or other support systems for care. The disparity between criminal justice statistics and victim self-disclosures support this conclusion.

Women frequently don't get help for their injuries. A critical gap remains in the delivery of health care to battered women, with many providers discharging a woman with only the presenting injuries being treated, leaving the underlying cause of those injuries not addressed. The same is true for victims of sexual violence – past histories of abuse can be triggered for women when undergoing health exams. Sexual assault victims may find health care providers unwilling to provide health care options such as emergency contraception based on their individual or institutional philosophy regarding victim culpability. Unfortunately, many health and mental health care providers still do not view sexual assault, dating and domestic violence, and stalking as public health issues and lack the knowledge and skills to intervene appropriately. Without knowledge of the impact of the violence on women, health care providers can leave victims and survivors at greater risk of further violence or at risk of additional trauma due to the experience in health settings.

Intimate Partner Violence and Domestic Violence

According to National Center for Injury Prevention and Control, Centers for Disease Control's *Injury Fact Book 2001–2002*, "intimate partner violence is actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girl-friend, or current or former dating partner. Intimate partners may be heterosexual or of the same sex."

According to the National Domestic Violence Hotline, domestic violence (DV) "can be defined as a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound someone. Domestic violence can happen to anyone of any race, age, sexual orientation, religion or gender. It can happen to couples who are married, living together or who are dating. Domestic violence affects people of all socioeconomic backgrounds and education levels."

In addition, stalking is often included among the types of DV. Domestic Violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. Most DV incidents are not reported to the police. About 20% of DV rapes or sexual assaults, 25% of physical assaults, and 50% of stalkings directed toward women are reported. Therefore, it is believed that available data greatly underestimate the true magnitude of the problem.

According to data from the Washington Association of Sheriffs and Police Chiefs (WASPC) Uniform Crime Reporting Section, *Crime in Washington* annual reports, and consistent with national trends, at least one-third of women who are murdered are killed by their current or former intimate partner. Between January 1, 1997 and June 30, 2004, domestic violence abusers killed 281 people in Washington. In 2003, according to the Washington State Domestic Violence Fatality Review, 44% of women who were murdered in Washington State were killed by their current or former husband or boyfriend.

Stalking generally refers to harassing or threatening behavior that an individual engages in repeatedly, such as following a person, making harassing phone calls, or vandalizing a person's property. Stalking is more prevalent than previously thought: 8 percent of women in the United States have been stalked at some time in their life; it is estimated that over 1 million women are stalked annually. Four out of five stalking victims are women and 38% of women who are stalked tend to be stalked by intimate partners.

Washington State has a well-developed network of programs and services for DV victims that provide advocacy, support, and shelter. Even though much has been done to support DV victims, the efforts do not meet the need. More needs to be done to prevent domestic violence as well as develop effective strategies to deal with the perpetrators.

Sexual Violence

Sexual violence is a term used to describe any type of sexual activity committed by one person without the consent of the other. It involves the use of threats, force, or violence, or any other form of coercion or intimidation. Sexual contact with a person who is unable to give consent is also considered sexual assault. This includes, but is not limited to, a person who is asleep, under the influence of drugs or alcohol, or otherwise impaired.

Sexual violence is a serious problem in our society and criminal in nature. According to the Washington Association of Sheriffs and Police Chiefs Uniform Crime Reporting statistics for 2004, there were 2,828 reports of attempted or completed rapes (by legal definitions) to law enforcement. Preliminary 2005 data shows 2,794 reports for the same crime. According to data from the National Crime Victimization Survey and the National Violence Against Women Survey, Washington data show that one in six women experience forcible rape in their lifetime. In a 2001 survey of women across Washington who were over 18, approximately 38% of women reported being sexually assaulted at least once in their lifetime.

Sexual violence affects the lives of many women and children, and some men. Although sexual assault has occurred throughout history, only in recent times have laws and social attitudes condemned these acts as violations. Historically and currently most victims do not come forward and when they do they are often greeted with a skeptical or blaming response. Services for victims did not exist until the early 1970's when the rape crisis movement emerged and victims were encouraged to come forward and speak out about their experiences. Crisis response, advocacy, counseling, and medical services were developed. The criminal justice system began to take these crimes seriously and began to vigorously investigate and prosecute offenders, particularly repeat offenders and offenders whose victims are children. There are currently over 40 agencies specifically dedicated to providing services for victims. Primary prevention efforts are underway across the State to build community capacity and ownership of the conditions that foster sexual violence.

In spite of the increased criminal justice response, many victims experience the criminal justice system as unsupportive and re-victimizing. Washington State has been in the forefront of promoting social change by recognizing the need for a multi-faceted approach, focusing on a variety of individual, relationship, community and societal level factors. In 1997, Washington State received a federal grant to fund prevention programs targeting sexual violence. In an effort to direct the resources most effectively, an advisory committee was formed. Through a series of meetings and discussions, the committee developed an innovative approach to advancing sexual violence prevention in the State. The committee identified the following goal for the State:

To impact the underlying causes of sexual violence through the shifting of ownership of solutions from social services to the community using a community development approach.[1]

This plan continues to offer guidance to the individuals, agencies, and communities receiving funding specifically targeted toward rape prevention efforts.

[1] Sexual Assault Prevention Plan for Washington State by Sharon Silas with Roxanne Lieb Prepared for the Office of Crime Victims Advocacy Department of Community, Trade and Economic Development and the Washington State Department of Health Injury Prevention Program

Data Collection

Accurate and comprehensive data is severely lacking. Longitudinal data is lacking and intervention effectiveness studies are critically needed. The lack of consistent information about the number of women affected by violence limits the ability to respond to the problem in several ways. It limits the ability to:

1. gauge the magnitude of violence against women in relation to other public health problems;
2. identify those groups at highest risk who might benefit from focused intervention or increased services;
3. monitor changes in the incidence and prevalence of VAW over time, which limits the ability to monitor the effectiveness of VAW intervention activities.

Accurate statistics about the prevalence and incidence of violence against women are especially difficult to obtain because most incidents are not reported to authorities and most victims do not seek services. Data collection efforts that measure the scope and magnitude of the situation of violence against women are hampered by a number of factors, including: 1) the influence of social and cultural norms in determining what constitutes violence, impeding universal consensus on a definition of violence against women; and, 2) changes in reported rates of abuse according to the definition of violence used, the way questions are asked, the type of target population, and the setting of the interview (privacy, familiarity of environment, etc.).

Higher quality and more timely incidence and prevalence estimates have the potential to be of use to a wide audience, including policymakers, researchers, public health practioners, advocates, service providers, and media professionals.

Violence against women requires a broad public health approach with comprehensive prevention strategies and a coordinated response from multiple sectors.

Recommended Strategies from the Injury Community Planning Group:

Note: Many strategies can be categorized as primary, secondary or tertiary. *Primary* strategies are approaches that take place before violence has occurred to prevent victimization. *Secondary* approaches decrease the amount of harm; decrease additional assaults; reduce the victim's vulnerability to future assaults, or decrease the perpetrator's likelihood of committing additional assaults. *Tertiary* strategies are long-term responses after violence has occurred to deal with the lasting consequences of violence.

Currently, there are no proven strategies for preventing violence against women or for successfully intervening with the victims of violence against women. The Injury Community Planning Group has identified some strategies that may have potential. Strategies # 1 and 2 are needed to develop a foundation for collecting critical data to accurately assess the problem and to develop effective strategies.

1. Develop a task force representing various VAW perspectives to successfully identify and evaluate promising interventions. (*Primary*)

2. Develop a task force representing various VAW perspectives to advise on technological development and to track services rendered and needed at the DV agency level, use of standardized data definitions and collection, and police incidences of DV/IPV at a minimum among police departments. (*Primary*)

3. Promote social norms campaigns, skill building activities, and other strategies that reflect positive gender roles as the norm. (*Primary*)

4. Build partnerships and coalitions with foundations, policy makers, community leaders and other organizations that can provide resources to accomplish primary prevention strategies. (*Primary*)

5. Provide tools, information, training, and resources to health care providers to support their role in prevention and early intervention for violence against women. (*Primary*)

6. Support individuals, communities and agencies in implementing community mobilization strategies focused on building ownership of prevention of violence against women at the local level. (*Primary*)

7. Provide routine, culturally appropriate and relevant data collection to measure the scope and impact of violence against women. (*Primary*)

8. Design, conduct and analyze surveillance data systems to measure violence against women, share results with key stakeholders and funding sources, and to assist in policy development and strategic planning. (*Primary*)

9. Public agencies need to create mechanisms for gathering accurate and comparable data at the state level on violence against women to take action to strengthen advocacy efforts, help policymakers understand the problem, and guide the design of preventive interventions. (*Primary*)

10. Work with State government and local communities to:

    a. support the development of programs for children who have witnessed abuse or for children who are in a household where abuse has taken place by making affordable, quality counseling available, and by providing training for mental health care providers. *(Primary)*

b. reduce barriers for victims of violence against women with limited English proficiency to access help from the criminal justice, civil justice, and social service systems. (*Tertiary*)

11. Encourage professionals involved in violence against women-related fields to build relationships between victims and community or system-based advocates. (*Tertiary*)

Resources:

1. The Washington State Department of Health. Health of Washington State website: http://www.doh.wa.gov/HWS.

2. *Findings and Recommendations from the Washington State Domestic Violence Fatality Review*, prepared by the Washington State Coalition Against Domestic Violence, December, 2002, www.wscadv.org and http://www.wscadv.org/projects/FR/index.htm#FRReports.

3. *Sexual Assault Experiences and Perceptions of Community Response to Sexual Assault: A Survey of Washington State Women*, supported by the Office of Crime Victims Advocacy, Washington State Office of Community Development, November, 2001.

4. *SPECIAL GUIDE: What Health Care Providers Can Do About Domestic Violence*, prepared by the Center for Health and Gender Equity for *Population Reports, Ending Violence Against Women*, Series L, No. 11, December 1999, http://www.infoforhealth.org/pr/l11edsum.shtml.

5. *Rape in Washington: A Report to the State*, prepared by the Charleston, South Carolina: National Violence Against Women Prevention Research Center, Medical University of South Carolina, Dean G. Kilpatrick, Ph.D. Kenneth J. Ruggerio, Ph.D., May 15, 2003, http://www.doh.wa.gov/hsqa/emstrauma/injury/pubs/Rape_in_Washington.pdf.

6. *Sexual Violence Prevention: Beginning the Dialogue* prepared by Centers for Disease Control and Prevention, Atlanta, Georgia, 2004, http://www.cdc.gov/ncipc/dvp/SVPrevention.pdf.

7. *The Facts on Health Care and Domestic Violence*, prepared by The Family Violence Prevention Fund, www.endabuse.org and http://www.endabuse.org/resources/facts/HealthCare.pdf, and http://www.who.int/mediacentre/factsheets/fs239/en/, www.fvpf.org/health.

8. *Intimate Partner Violence Fact Sheet*, prepared by the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Atlanta, Georgia, http://www.cdc.gov/ncipc/dvp/dvp.htm.

9. *Understanding Sexual Violence Using the Public Health Model*, prepared by the Washington Coalition of Sexual Assault Programs, Research & Advocacy Digest: Linking Advocates & Researchers, Volume 5, January 2, 2003, http://www.wcsap.org/pdf/RAD5-2.pdf.

10. *Prevention of Sexual Assault and Domestic Violence*, prepared by the National Electronic Network on Violence Against Women, National Resource Center for Domestic Violence, David A. Wolfe and Peter G. Jaffe, January, 2003.

11. *Chapter 2: Improving the Health and Mental Health Care Systems' Responses to Violence Against Women, Toolkit to End Violence Against Women*, prepared by the National Advisory Council on Violence Against Women and the Violence Against Women Office, http://toolkit.ncjrs.org/.

12. The World Health Organization, http://www.who.int/mediacentre/factsheets/fs239/en/.

13. *National Concensus Guildlines on Identifying and Responding to Domestic Violence Victimization,* prepared by the Family Violence Prevention Fund, Website: www.endabuse.org.

14. National Sexual Violence Resource Center, Website: http://www.nsvrc.org/.

15. *Violence Against Women Prevention Programming: Report of What Is in Use*, prepared by the National Violence Against Women Prevention Research Center, website: www.vawprevention.org.

16. *A Vision for Prevention: Key Issues and Statewide Recommendations for Primary Prevention of Violence Against Women in Michigan*, prepared by the Michigan Coalition Against Domestic and Sexual Violence, Website: http://www.mcadsv.org/.

17. National Online Resource Center on Violence Against Women, Website: vawnet.org.

18. *Stalking in America: Findings From the National Violence Against Women Survey, April,1998, prepared by* National Institute for Justice Centers for Disease Control (NIJCDC) Website: http://www.ncjrs.gov/pdffiles/169592.pdf.

19. *Rape Prevention and Education Grant Program: Preventing Sexual Violence in the United States, 2004,* prepared by the Department of Health and Human Services Centers for Disease Control and Prevention.

20. The National Domestic Violence Hotline Website: http://www.ndvh.org/educate/what_is_dv.html.

[i] U.S. Department of Health & Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, *Intimate Partner Violence Surveillance, Uniform Definitions and Recommended Data Elements*, Atlanta, Georgia, 1999.

Preventing Violence Against Women (VAW) in Washington State

Because we have these resources…

…we are able to implement these strategies/activities

…we are able to have these outputs…

…so that we achieve these outcomes for our citizens.

Inputs

- Funding
- Data
- State Agency Staff (DOH, CTED, DOC, WSP)
- Local partners & community organizations
- Injury Community Planning Group
- Print and web materials
- Research-based best practices or promising interventions
- Criminal justice system

Strategies/Activities

- Collect critical data to assess the magnitude of the problem
- Assess the effectiveness of interventions
- Promote & implement effective interventions in communities through coalitions
- Educate professionals, community members, and family on early identification and intervention skills

Outputs

- Organizations & agencies participating in data collection and synthesis
- Research & identification of best practices to prevent VAW
- Health, mental health, schools, organizations & communities implementing best practices
- Community, organizational, & law enforcement trainings in early identification & intervention skills

Short Term Outcomes

KNOWLEDGE

- ↑ identification & dissemination of best practices
- ↑ knowledge of VAW warning signs & intervention strategies for health, mental health care and criminal justice professionals
- ↑ public knowledge of VAW warning signs

Intermediate Outcomes

CAPACITY

- ↑capacity to gather accurate data for assessment and intervention
- ↑ community capacity to implement VAW prevention programs based on best practices
- ↑ assessment & referral training for health and mental health clinicians
- ↑ health & mental health organizations identified as partners

BEHAVIOR

- ↑ willingness of women to report violence to law enforcement, health care professionals, friends and family
- ↑ women's seeking & using resources
- ↑ recognition of warning signs; ↑ support and involvement from family, friends, neighbors

Long Term Outcomes

- ↓ rate of physical assaults
- ↓ rate of physical assaults by current or former intimate partners
- ↓ rate of rape or attempted rape
- ↓ rate of sexual assault other than rape
- ↑ criminal sentences for VAW offenders

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